UNIFORM EXAMINATION PROGRAM FOR

CONTRACT YEAR 2003

ADJUSTED COMMUNITY RATE SUBMISSIONS

Name of M+C Organization: _____

M+C Organization's H Number: _____

Contract Period: _____

Type of Plan(s): _____

Names of Contact Personnel at M+C Organization:

_____

M+C Organization Address: _____

_____

_____

Entrance Conference Date:

_____

Exit Conference Date:

_____

Audit Manager:

_____

UNIFORM EXAMINATION PROGRAM FOR
ADJUSTED COMMUNITY RATE SUBMISSIONS

INTRODUCTION

Federal regulations require each Medicare+Choice (M+C) organization to compute a separate adjusted community rate (ACR) for each M+C coordinated care, private fee-for-service, or religious fraternal benefit health care plan offered to Medicare beneficiaries. An M+C organization offering a plan with a medical savings account plan (MSA) must submit the Centers for Medicare and Medicaid Services' (CMS's) ACR worksheets with certain information, but not a complete ACR calculation. To compute the ACR, an M+C organization with non-Medicare enrollees calculates an initial rate for the contract period that represents the average premium that it would charge its general non-Medicare-eligible population for the same type of plan (e.g., health maintenance organization). In addition, the organization must compute, if possible, corresponding information for the base period. The ACR worksheet will use the initial rate and the base period data to produce non-Medicare trend values. The worksheet then multiplies the non-Medicare trend values by Medicare base period costs, if available, to provide a projection of contract year costs. M+C organizations without non-Medicare enrollees and/or without Medicare enrollees in the base period must follow a different methodology. Either way, the ACR methodology is flexible enough to allow M+C organizations to modify the calculations to reflect their best estimate of projected costs for the contract year.

M+C organizations must submit such calculations on the worksheets that accompany CMS's ACR instructions and must supply additional supporting material as requested. All data submitted as part of the ACR process are subject to audit by CMS or any person or organization CMS designates as its representative as required by 42 CFR 422.502(d)(1)(i). The management of the M+C organization offering the plan certifies the ACR proposal (ACRP) as follows:

Certification

I hereby certify that I have examined the accompanying Adjusted Community Rate proposal and attached worksheets for the contract period identified in Part IA, line 7. To the best of my knowledge and belief, this proposal contains true and correct statements prepared from the books and records of the contracting organization in accordance with applicable instructions, except as noted. In addition, I certify this proposal agrees with the Plan Benefit Package form submitted for the same contract period.

_____ _____
Chief Executive Officer Date

_____ _____
Chief Financial Officer Date

_____ _____
Vice President, Marketing Date

Management's certification provides the written basis of an assertion that permits the auditor(s) to express a conclusion about management's assertion after the auditor(s) perform the appropriate attestation procedures.

Requirement for Periodic Audits

To fulfill its responsibilities to manage the M+C program (Part C of Medicare), including the management of the ACR proposal process, CMS conducts various audits of M+C organizations and the documents they submit under Part C. Those audits include the periodic (annual) audits, required by law (section 1857 (d)(1) of the Balanced Budget Act of 1997), of one-third of all M+C organizations offering M+C plans.

Application of this Examination Program

As stated above, CMS is required to examine annually at least one-third of all M+C organizations offering M+C plans. This Uniform Examination Program for Adjusted Community Rate Proposals is designed to facilitate the examinations.

Auditors should use this document to review the ACR plan(s). A final audit plan for any specific M+C organization is dependent on criteria such as:

- Type of plan: (e.g., provider sponsored organization);
- Scope of audit: (e.g., broad or targeted);
- Organizational characteristics: (e.g., new, no non-Medicare enrollees, profit vs. non-profit); and
- Audit objectives mutually agreed upon by CMS and the auditor(s).

Auditors should familiarize themselves with CMS's instructions for completing the ACR proposal and with other relevant material .

UNIFORM EXAMINATION PROGRAM FOR
ADJUSTED COMMUNITY RATE SUBMISSIONS

PLAN NAME: _____
M+C ORGANIZATION NUMBER: _____
CONTRACT YEAR: _____

SECTION I: PLANNING

AUDIT OBJECTIVES:

1. To plan the proposed examination engagement:

   a. In accordance with the following pronouncements: generally accepted auditing standards (GAAS) and generally accepted governmental auditing standards (GAGAS), as prescribed by the Government Auditing Standards (1994 revision)'

   b. In accordance with special directives and procedures as determined by CMS, and

   c. In a manner that is efficient and that meets CMS's objectives.

2. To plan the sections of the audit program in which contracted actuaries are required to participate:

   a. In accordance with the applicable Actuarial Standards of Practice (ASOP), as promulgated by the American Academy of Actuaries.

   b. In accordance with special directives and procedures as determined by CMS, and

   c. In a manner that is efficient and that meets CMS's objectives.

3. To appraise all source documents that may contribute to the understanding and evaluation of the M+C organization's development and submission of ACRPs. Those include any necessary information from the material that the M+C organization must provide under 42 CFR 422.502 (d), (e), and (f).

AUDIT PROCEDURES:	Initial & Date	W/P Ref.

1. Review the M+C organization's ACRP and document the following data:

   a. Type of Plan

      (1) For coordinated care plans:

         (a) Health maintenance organizations — HMO

         (b) Health maintenance organizations with point-of-service option — HMOPOS

         (c) Provider-sponsored organizations — PSO

         (d) Preferred provider plans — PPO

UNIFORM EXAMINATION PROGRAM FOR
ADJUSTED COMMUNITY RATE SUBMISSIONS

PLAN NAME: _____
M+C ORGANIZATION NUMBER: _____
CONTRACT YEAR: _____

AUDIT PROCEDURES:		Initial & Date	W/P Ref.
(e) Other	CCOTH		
(2) For M+C private fee-for–service plans	PFFS		
(3) For M+C MSA plans	MSA		
(4) For other types of plans	OTHER		
(5) Religious fraternal benefit plans	RFB	_____	_____

Type of Plan: _____

_____

b. Determine if total enrollment can be identified by plan. _____ _____

c. Ensure that the organization is submitting support for the CMS-approved version of each ACR worksheet.

(1) Worksheet A – Cover Sheet _____ _____

(2) Worksheet A1 – Service Area and Estimate of Annual Payment Rate _____ _____

(3) Worksheet B – Base Period Costs _____ _____

(4) Worksheet C – Premiums & Cost Sharing _____ _____

(5) Worksheet D – Expected Cost & Variation _____ _____

(6) Worksheet F – Adjusted Community Rate for Optional Supplemental Benefits

2. Acquire copies of CMS's approved ACRPs (ACR and PBP) from CMS and review the desk review findings. _____ _____

3. Review, with CMS, the criteria for which the plan was selected for examination. Document CMS's inquiries to ensure that the specifics of the inquiries are included in the scope of the examination. _____ _____

4. Complete the planning control document sections:

UNIFORM EXAMINATION PROGRAM FOR
ADJUSTED COMMUNITY RATE SUBMISSIONS

PLAN NAME: _____
M+C ORGANIZATION NUMBER: _____
CONTRACT YEAR: _____

AUDIT PROCEDURES:	Initial & Date	W/P Ref.
a. Understanding the engagement.	_____	_____
b. Planning considerations.	_____	_____
c. Staffing and scheduling.	_____	_____
d. Planning conferences.	_____	_____
e. M+C organization correspondence.	_____	_____
f. Obtain names and telephone numbers of key personnel from CMS	_____	_____
g. Provide CMS and the M+C organization written notice of the date of the survey and entrance conference, and when the audit team will be on site performing the fieldwork. This is to ensure the availability of the M+C organization's staff to answer inquiries and to provide information.	_____	_____
5. Obtain and/or review the following items not already in CMS's possession. Maintain a current file.	_____	_____
a. An organization chart illustrating the ownership, operation, and organizations represented.	_____	_____
b. An overall description of the operation of the M+C organization's financial, medical delivery, and record-keeping systems.	_____	_____
c. List of agreements, (including marketing and management agreements), contracts, subcontracts, and franchises that affect the costs of health care services to the Medicare beneficiaries.	_____	_____
d. Supporting schedules used in the development of the ACR worksheets.	_____	_____
e. M+C organization's contract with CMS.	_____	_____
f. M+C organization's marketing materials.	_____	_____
g. Records of CMS disciplinary actions affecting the M+C organization, if applicable and necessary.	_____	_____
h. Any state filings (e.g., rate filings, orange blanks).	_____	_____
i. Base period year-end financial statements.	_____	_____

UNIFORM EXAMINATION PROGRAM FOR
ADJUSTED COMMUNITY RATE SUBMISSIONS

PLAN NAME: _____
M+C ORGANIZATION NUMBER: _____
CONTRACT YEAR: _____

AUDIT PROCEDURES:	Initial & Date	W/P Ref.
6. Determine if CMS has recently audited the M+C organization's ACR. If so, review the findings and working papers.	_____	_____

UNIFORM EXAMINATION PROGRAM FOR
ADJUSTED COMMUNITY RATE SUBMISSIONS

PLAN NAME: _____
M+C ORGANIZATION NUMBER: _____
CONTRACT YEAR: _____

SECTION II: WORKSHEET A – COVER SHEET

AUDIT OBJECTIVES:

1. To test management's assertion that the non-Medicare cost information (Part IB, columns a and b, lines 1-4) is calculated as prescribed by CMS's instructions for completing the ACRP.

2. To determine whether executives of the M+C organization certified the ACRP.

AUDIT PROCEDURES:	Initial & Date	W/P Ref.
1. Compare the ACRP contract year as reported in the desk review file to the data reported in Part IA, line 7.	_____	_____
2. Request support for the base period collections and its components (direct medical care, administration, and additional revenues) shown in Part IB, column a, lines 1-4. Request comparable support for the initial rate shown in Part IB, column b, lines 1 through 4. Both the initial rate and base period collections (including the components) should include data for the same type of plan (e.g., HMO, HMOPOS, PPO) as the Medicare + Choice plan being priced in the ACR. Using the support data, ensure that the two calculations are reasonable. Detailed support for non-Medicare trend calculations is not necessary. A document referencing the trend used is sufficient (e.g., state rate filings,) Document findings/observations. NOTE: Document instances where an M+CO did not follow CMS's instructions as an observation, even though the reported ACR values were not materially affected.	_____	_____
3. Ensure that the certification statement is signed and dated by the chief executive officer, the chief financial officer, and the vice president of marketing. See the ACR instructions for more information on signatures required for resubmitted ACRPs.	_____	_____
4. Verify the accuracy of the stabilization fund.	_____	_____
5. Verify the accuracy of the part B premium reduction.	_____	_____

PLAN NAME: _____
M+C ORGANIZATION NUMBER: _____
CONTRACT YEAR: _____

SECTION III: WORKSHEET A1 – SERVICE AREA AND ESTIMATE OF ANNUAL PAYMENT RATE

BACKGROUND:

Worksheet A1 is provided for two purposes: to identify the service area for the contract year of the M+C plan being priced in an ACR, and to calculate the plan's Average Payment Rate (APR). The worksheet is pre-populated with data so that M+C organizations have to make only limited inputs. Inputs are required only for the plan service area, actual payments received in CY2002, membership projections, and the risk factors. The worksheet has embedded formulas that calculate the plan APR. If an organization is not satisfied with the results of the automatic calculation, however, it can make adjustments in column j.

AUDIT OBJECTIVES:

1. To test management's assertion that the risk factor calculations are reasonable.
2. To determine whether management employed reasonable assumptions projecting plan membership and have included all appropriate types of enrollees.
3. To test management's assertion that any adjustments it makes in column l and/or column d of the worksheet are reasonable.
4. To test management's assertions that the APR is not materially misstated.

AUDIT PROCEDURES:	Initial & Date	W/P Ref.
1. Compare the projected Medicare average membership in column l to the CMS enrollment data for reasonableness. Verify that the total membership of all plans offered by the M+C organization is reasonably consistent with the total for the related H number. (That information will be provided by CMS.) Ensure that the projected enrollment listed in column l and summed in Part II is specific for each plan. Out-of-area enrollees should be included under state-county code 99999. ESRD and Hospice members should be included in the APR calculation, but may be included with the out-of-area members under state-county code 99999. For more information on ESRD and Hospice issues, see Appendix A of the ACR instructions. Document findings.	_____	_____

UNIFORM EXAMINATION PROGRAM FOR
ADJUSTED COMMUNITY RATE SUBMISSIONS

PLAN NAME: _____
M+C ORGANIZATION NUMBER: _____
CONTRACT YEAR: _____

2. Verify the CY 2002 actual monthly payment rate (column c) and any appropriate adjustments (i.e., to add back items CMS withheld from 2002 payments like user fees). Trace the data in column c to the actual payment records from CMS's Automated Plan Payment System and those recorded on the organization's general ledger. Verify any adjustments. Document any discrepancies. _____ _____

3. Review the plan-level adjustments (column l). Possible plan-level adjustments could include, but are not limited to, adjustments from H#-level to plan-level payments or adjustments for differences in expected demographics. Adjustments should be made to more closely approximate the estimated payment the M+CO expects to receive from CMS for that plan. Comment upon the reasonableness of the assumptions. _____ _____

4. Verify the county payment rates for CY 2002 (column d) and CY 2003 (column f). Compare the payment rates in the approved worksheet to the rate table on CMS's Web site. Document any differences. _____ _____

5. If the risk score changed between CY 2002 and CY 2003, review the change for reasonableness. If the M+CO entered the same risk score for both CY 2002 and CY 2003, make sure the risk characteristics are the same between 2002 and 2003. Document any findings. _____ _____

6. Document instances where an M+CO did not follow CMS's instructions with respect to the items discussed above, even though any reported ACR values were not materially affected. _____ _____

PLAN NAME: _____
M+C ORGANIZATION NUMBER: _____
CONTRACT YEAR: _____

SECTION IV: WORKSHEET B – MEDICARE BASE PERIOD COSTS

BACKGROUND:

Information reported on Worksheet B is based primarily on the actual costs incurred by the M+C organization and any cost sharing collected for the base period of the ACR. CMS expects data for Worksheet B to be developed from actual costs reported by the M+C organization's general ledger or claims system on a GAAP basis and converted to per-member, per-month (PMPM). The methodology employed by the M+C organization will be unique to the individual organization and will be based on the M+C organization management's assertion that the information presented is cost data reported by the M+C organization's books of account and systems of internal control. *Exception:* The data required on coordination of benefits (COB) for Medicare generally should not reflect actual data. See Item 2 below.

In addition:

1. With respect to lines 1-25, column b (Medicare-Covered Benefits), column c (Additional Benefits), column d (Mandatory Supplemental Benefits), and column e (Optional Supplemental Benefits) the data for 2 or more columns should not be combined in one column.

2. Lines 1-18 should include cost sharing charged for those benefits.

3. Line 20 (COB-Working Medicare) column b and line 21 (COB-Other) columns b, c, d, and e all must represent what the M+C organization was entitled to collect from the enrollee and the primary payer when Medicare was the secondary payer for a given service.

4. With respect to lines 1-18 of column b and lines 1-19 of columns c, d, and e, base period data should be shown under the appropriate column for the contract year. For example, if a health care benefit had been a mandatory supplemental benefit in the base period, but will be an additional benefit in the contract year, then the base year data would be shown in column c (Additional Benefits).

5. Lines 1 through 22 and line 25 should include cost sharing, where appropriate.

6. Line 26, columns b, c, d, and e are amounts collected by the M+C organization from enrollees or on behalf of enrollees in the form of premiums and cost sharing. This line should not include COB or the payment received from CMS.

7. If a plan had no Medicare enrollees in the base period, its Worksheet B should be blank.

UNIFORM EXAMINATION PROGRAM FOR
ADJUSTED COMMUNITY RATE SUBMISSIONS

PLAN NAME: _____
M+C ORGANIZATION NUMBER: _____
CONTRACT YEAR: _____

AUDIT OBJECTIVES:

1. To test management's assertions that the data reported on Worksheet B agrees with or is based upon the full costs reported in the M+C organization's books of account.

2. To test management's assertion that the cost finding methodology employed is based on concepts supported by generally accepted accounting principles (GAAP).

3. To ensure the premium collected in the base period did not exceed the premium amount approved by CMS.

AUDIT PROCEDURES:	Initial & Date	W/P Ref.
1. Prepare a detailed report describing the costing methodology employed by the M+C organization to substantiate the information reported on Worksheet B.	_____	_____
2. Trace the cost information reported on Worksheet B to the M+C organization's general ledger. Document differences.	_____	_____
3. Trace the cost sharing information reported on Worksheet B to supporting documentation. If the M+CO does not have record of the actual amounts collected, then verify the reasonableness of the estimates. Verify that the amounts collected or estimated are consistent with the amounts described in the Plan Benefit Package (PBP) for the base period.	_____	_____
4. Trace total direct medical care and administration for all plans offered by the M+C organization to the M+C organization's certified financial statements. If the M+C organization does not have certified GAAP financial statements, then obtain a reconciliation tracing the information in the certified statements to GAAP standards and then to the individual ACRs. Administration may include any cost of doing business (e.g., income taxes, goodwill, royalties). Document differences.	_____	_____
5. With respect to lines 1-25, column b (Medicare-Covered Benefits), column c (Additional Benefits), column d (Mandatory Supplemental Benefits), and column e (Optional Supplemental Benefits) the data for 2 or more columns should not be combined in one column. If the data in any of those columns had to be apportioned because of the lack of accounting data, verify the apportionment methodology. Pay close attention to instances where there is a small benefit cost, but large administrative or additional revenue amounts. Document findings.	_____	_____

UNIFORM EXAMINATION PROGRAM FOR
ADJUSTED COMMUNITY RATE SUBMISSIONS

PLAN NAME: _____
M+C ORGANIZATION NUMBER: _____
CONTRACT YEAR: _____

6. Ensure the coordination of benefits amounts on lines 20 and 21 are reported as described in item number 2 of the Background section. If the claims system aggressively identifies claims that may deem the M+CO a secondary payer, document these observations and do not list this as a finding. (An example of an aggressive system is one that flags claims with diagnoses common to automobile accidents or workman's compensation injuries or flags claims for members with other health insurance.) _____ _____

7. Verify that line 29 includes all premiums collected and cost sharing that should have been collected from enrollees (or collected on behalf of enrollees from sources such as employer groups) and that line 29 excludes capitation payments received from CMS. In addition, premiums and cost sharing charged for extra benefits only offered to employer groups must be excluded. _____ _____

8. Confirm that reinsurance premiums and user fees are included in administration and reinsurance recoveries are included in direct medical care. _____ _____

9. Ensure that base period costs do not include "extra" benefits offered only to employer groups. _____ _____

10. Document instances where an M+CO did not follow CMS's instructions with respect to the items discussed above, even though any reported ACR values were not materially affected. _____ _____

11. Optional procedures, if any:

    CMS representatives may request that specific tests be performed to develop findings in greater detail. Document these additional procedures, if any, including CMS's rationale and objectives for performing the additional procedures. _____ _____

PLAN NAME: _____
M+C ORGANIZATION NUMBER: _____
CONTRACT YEAR: _____

SECTION V: WORKSHEET C – PREMIUMS & COST SHARING

BACKGROUND:

Worksheet C reports the premiums and cost sharing that the M+C organization intends to charge Medicare enrollees on a per-member, per-month basis for the contract year. In addition:

1. Lines 1 through 21:

a. Columns a through d report the cost sharing that is expected to be charged to Medicare enrollees for Medicare-covered benefits, additional benefits, mandatory supplemental benefits, and optional supplemental benefits respectively. Cost sharing entries should not be negative.

b. Column e reflects the premiums expected to be charged for optional supplemental benefits.

c. Column f calculates the sum of columns d and e.

2. Line 26: Columns a and c of line 26 are the total premium expected to be charged to Medicare enrollees for basic benefits and mandatory supplemental benefits.

AUDIT OBJECTIVES:

To determine whether the cost sharing estimates represent reasonable projections of the experience to be expected in the Contract period.

AUDIT PROCEDURES:	Initial & Date	W/P Ref.
1. After review of the documentation submitted by the M+CO with the ACR, prepare a request to the M+CO for such additional information as is need to carry out the audit procedures of this section. ***Note: It is not necessary that the actuary be on-site during the "survey" phase of the audit.***	_____	_____
2. Using the documentation submitted, ensure that the per-service cost sharing assumptions are consistent with the comparable figures found in the Plan Benefit Package (PBP). Document instances where there are inconsistencies.	_____	_____

PLAN NAME: _____
M+C ORGANIZATION NUMBER: _____
CONTRACT YEAR: _____

3. Determine if the cost sharing projections in Worksheet C are reasonable, individually, and in aggregate.
   a. Review should take into consideration:
      i. Per-service cost sharing assumptions.
      ii. Recent plan experience.
      iii. Trend in utilization and other residual sources.
      iv. Limits on enrollee out-of-pocket expenditures.
      v. Other information available to the actuary, including, but not limited to, industry experience adjusted for specific plan characteristics.
      vi. The appropriate Actuarial Standards of Practice (ASOP), especially applicable sections of ASOP No. 8, *Regulatory Filings for Rates and Financial Projections for Health Plans*. ***Caution: The M+COs are not responsible for developing health filings that meet the standards of ASOP No. 8, and this should be clearly stated in the Actuarial Report. The objective is to investigate and report what procedures and assumptions were employed in the development of the ACR, and how these compare to those contained in the ASOPs.***
   b. The actuary should document instances where the cost sharing projections are determined not to be reasonable. Documentation should include the actuary's best estimate of the cost sharing liability and the resulting impact on the ACR projection.

_____ _____

4. Prepare a section of the Actuarial Report covering the ACR projections of enrollee cost sharing as defined in Section VIII, Completion of the Examination, of these guidelines. _____ _____

PLAN NAME: _____
M+C ORGANIZATION NUMBER: _____
CONTRACT YEAR: _____

SECTION VI: WORKSHEET D - EXPECTED COST & VARIATION

BACKGROUND:

Worksheet D reports the trended value of the benefit costs (costs on worksheet B multiplied by the trend from Worksheet A) and adjustments (expected variations) needed to cause the ACR computation to more closely approximate the costs to be incurred for the Medicare population during the contract period. The adjustments may include changes in Medicare coverage since the base period, projected changes in trend considerations (e.g., inflation, technology, utilization) and corrections of errors in the formulae in the electronic ACR.

An M+C organization might not have had any non-Medicare enrollees in the base period and/or might have none in the contract period. In addition, an M+C plan might not have had any Medicare enrollees in the base period. In those instances, the ACR worksheets will not compute trended values for the contract year. Instead, the organization should have entered the plan's contract year projections on Worksheet D as expected variations.

The review of Worksheet D will focus on the "adjusted value" entries, which represent the trended values plus the adjustments.

AUDIT OBJECTIVES:

1. To determine whether the direct medical care (DMC) "Adjusted Value" estimates represent reasonable projections of the experience to be expected in the Contract period.

2. To test management's assertion that the adjustments to administration and additional revenue entries are founded on reasonable financial assumptions and statistical data.

	Initial & Date	W/P Ref.
AUDIT PROCEDURES:		
1. After review of the documentation submitted by the M+CO with the ACR, prepare a request to the M+CO for such additional information as is need to carry out the audit procedures of this section. ***Note: It is not necessary that the actuary be on-site during the "survey" phase of the audit.***	_____	_____
2. Determine if the DMC "Adjusted Value" projections are reasonable, individually, and in aggregate.		
a. Review should take into consideration:		
i. Recent plan experience, adjusted for changes in plan benefits.		
ii. Trend in provider reimbursement, utilization, intensity, and other sources.		
iii. Consistency with cost sharing projections.		
iv. Other information available to the actuary, including, but not limited to, industry experience adjusted for specific plan characteristics.		
v. Reinsurance contracts.		
vi. The appropriate Actuarial Standards of Practice (ASOP),	_____	_____

PLAN NAME: _____
M+C ORGANIZATION NUMBER: _____
CONTRACT YEAR: _____

AUDIT PROCEDURES:	Initial & Date	W/P Ref.
especially applicable sections of ASOP No. 8, *Regulatory Filings for Rates and Financial Projections for Health Plans*. ***Caution: The M+COs are not responsible for developing health filings that meet the standards of ASOP No. 8, and this should be clearly stated in the Actuarial Report. The objective is to investigate and report what procedures and assumptions were employed in the development of the ACR, and how these compare to those required by the ASOPs.***		
b. The actuary should document instances where the DMC "Adjusted Value" projections are determined not to be reasonable. Documentation should include the actuary's best estimate of the DMC "Adjusted Value(s)" and the resulting impact on the ACR projection	_____	_____
3. Determine if the adjustments made to administration, if any, are reasonable and are made to more closely approximate the cost that would be incurred for the Medicare population during the ACR contract period. Document findings.	_____	_____
4. Determine if an increase in additional revenue has appropriate justification. Appropriate justification does not include "balancing of Worksheet E." Document findings.	_____	_____
5. Prepare a section of the Actuarial Report pertaining to the "Adjusted Value" components of Worksheet D as defined in Section VIII, Completion of the Examination, of these guidelines.	_____	_____

PLAN NAME: _____
M+C ORGANIZATION NUMBER: _____
CONTRACT YEAR: _____

SECTION VII: WORKSHEET F – ADJUSTED COMMUNITY RATE FOR OPTIONAL SUPPLEMENTAL BENEFITS

BACKGROUND:

Worksheet F reports the total projected price (expected medical cost less cost sharing plus administrative cost, and additional revenue), cost sharing, and premium for each optional supplemental benefit package.

The review of Worksheet F will focus on any supporting documentation regarding the calculation of the entries on Worksheet F.

AUDIT OBJECTIVE:

1. To determine whether the total projected price (as comprised of expected medical cost less cost sharing plus administrative cost, and additional revenue), cost sharing, and premium estimates represent reasonable projections of the experience to be expected in the Contract period.

2. To determine if the premium is appropriate relative to the actuarial value of the benefit and cost sharing provisions of each benefit package.

	Initial & Date	W/P Ref.
AUDIT PROCEDURES:		
1. After review of the documentation submitted by the M+CO with the ACR, prepare a request to the M+CO for such additional information as is need to carry out the audit procedures of this section. ***Note: It is not necessary that the actuary be on-site during the "survey" phase of the audit.***	_____	_____
2. Determine if the components of the total projected price are reasonable for each benefit package, individually. Review should take into consideration:		
vii. Recent plan experience, adjusted for changes in plan benefits.		
viii. Trend in provider reimbursement, utilization, intensity, and other sources.		
ix. Consistency with cost sharing projections.		
x. Other information available to the actuary, including, but not limited to, industry experience adjusted for specific plan characteristics.		
xi. Reinsurance contracts.		
xii. The appropriate Actuarial Standards of Practice (ASOP), especially applicable sections of ASOP No. 8, *Regulatory Filings for Rates and Financial Projections for Health Plans*. ***Caution: The M+COs are not responsible for developing health filings***	_____	_____

UNIFORM EXAMINATION PROGRAM FOR
ADJUSTED COMMUNITY RATE SUBMISSIONS

PLAN NAME: _____
M+C ORGANIZATION NUMBER: _____
CONTRACT YEAR: _____

AUDIT PROCEDURES:	Initial & Date	W/P Ref.
that meet the standards of ASOP No. 8, and this should be clearly stated in the Actuarial Report. The objective is to investigate and report what procedures and assumptions were employed in the development of the ACR, and how these compare to those required by the ASOPs.		
b. The actuary should document instances where the projections are determined not to be reasonable. Documentation should include the actuary's best estimate of the appropriate estimates and the resulting impact on the ACR projection	_____	_____
3. Determine if the cost sharing estimates are appropriate relative to the benefit provisions of each benefit package.	_____	_____
4. Determine if the premium is appropriate relative to the benefit and cost sharing provisions of each benefit package.	_____	_____
5. Prepare a section of the Actuarial Report pertaining to the components of Worksheet F as defined in Section VIII, Completion of the Examination, of these guidelines.	_____	_____

PLAN NAME: _____
M+C ORGANIZATION NUMBER: _____
CONTRACT YEAR: _____

SECTION VIII: COMPLETION OF THE EXAMINATION

OBJECTIVES:

1. To document the completion of the examination, adhere to the auditors' quality control procedures, and communicate the audit findings to CMS and the M+C organization.

2. To indicate clearly, if possible, the extent to which an ACR would be affected by changes needed to make it both reasonable and in synch with CMS policies and instructions.

PROCEDURES:	Initial & Date	W/P Ref.
1. Notify CMS if the auditor(s) suspects fraud by the M+C organization.	_____	_____
2. Prepare a report issuing an opinion on the reasonableness of the ACR worksheets. Using the model report format, advise CMS of the results of the procedures performed, summarizing all findings and observations, and the dollar amount of those findings, if possible. Policy issues should not be included in the report, but instead should be in a letter under separate cover. For findings where the effect can not be quantified, include an explanation as to why. Minor modifications to the model report format are permissible to meet specific needs, but must have CMS approval first.	_____	_____
3. The Actuary is required to prepare an Actuarial Report that communicates the actuary's professional conclusions and recommendations regarding the reasonableness of projections contained in Worksheet C, D and F (if applicable). The actuary should also assist the auditor in ascertaining that the enrollment projections in Worksheet A1, the apportionment method used to allocate benefits in Worksheet B and the cost sharing estimates both in Worksheets A & B are all appropriate.		
a. The report should conform to the appropriate Actuarial Standards of Practice (ASOP), as promulgated by the Actuarial Standards Board. Particular emphasis should be placed on the following ASOPs:		
i. ASOP No. 8, *Regulatory Filings for Rates and Financial Projections for Health Plans*. Particular focus should be placed on the sections dealing with the Recognition of Benefit Plan Provisions (Sec. 5.2), Consistency of Business Plan and Assumptions (5.3), Reasonableness of Assumptions (5.4), and Use of Past Experience to Project Future Results (5.5). ***Caution: The M+COs are not responsible for developing health filings***	_____	_____

PLAN NAME: _____
M+C ORGANIZATION NUMBER: _____
CONTRACT YEAR: _____

	Initial & Date	W/P Ref.

PROCEDURES:

that meet the standards of ASOP No. 8, and this should be clearly stated in the Actuarial Report. The objective is to investigate and report what procedures and assumptions were employed in the development of the ACR, and how these compare to those required by the ASOPs.

ii. ASOP No. 23, *Data Quality*, with emphasis on Section 5, Analysis of Issues and Recommended Practices, and Section 6, Communications and Disclosures. ***Caution: The M+COs are not responsible for developing health filings that meet the standards of ASOP No. 23, and this should be clearly stated in the Actuarial Report. The objective is to investigate and report on the selection and review of the data used in the development of the ACR, and how these compare to what is required by the ASOPs***.

b. The report should include a description of the method used by the M+CO to estimate the expenditures for benefits PMPM in the Contract period.

c. The report should include an assessment of the reasonableness of the 2003 average payment rate (APR), as reported on Worksheet A1. In their assessment of the reasonableness of the APR, the actuary shall consider the data, methodology, and assumptions used in its projection.

d. The report should include an assessment of the reasonableness of the ACR projection of Worksheet C enrollee cost sharing and Worksheet D "Adjusted Value" figures. This analysis is to be performed on both individual benefit categories, and on all benefit categories in their entirety. Such reasonableness should be determined using all information available to the actuary and the actuary's judgement. To the extent that estimates are determined to be unreasonable, the actuary is to report on their "best estimate" of the figure.

e. The report should compare the documentation maintained by the M+CO with the standards of ASOP No. 31, "Documentation in Health Benefit Plan Ratemaking". ***Caution: The M+COs are not responsible for providing documentation that meets the standards of ASOP No. 31, and this should be clearly stated in the Actuarial Report. The objective is to investigate and report what documentation is maintained by the***

UNIFORM EXAMINATION PROGRAM FOR
ADJUSTED COMMUNITY RATE SUBMISSIONS

PLAN NAME: _____
M+C ORGANIZATION NUMBER: _____
CONTRACT YEAR: _____

	Initial & Date	W/P Ref.
PROCEDURES:		
M+CO, and how this compares to what would be required by the ASOPs.		

UNIFORM EXAMINATION PROGRAM FOR
ADJUSTED COMMUNITY RATE SUBMISSIONS

PLAN NAME: _____
M+C ORGANIZATION NUMBER: _____
CONTRACT YEAR: _____

4. Provide written notification of the date of the exit conference to the M+C organization and CMS. Also provide CMS and the M+C organization a written summary of the findings. Request that an initialed or acknowledged copy be available at the exit conference. _____ _____

5. Obtain a signed letter of representation prior to the end of fieldwork and include this as an attachment to the report. Ensure that the M+C organization has not materially altered the model letter. _____ _____

6. Conduct an exit conference:

   a. Prepare an agenda for the exit conference in advance to ensure that all relevant topics are covered. _____ _____

   b. Invite CMS to the exit conference. _____ _____

   c. Provide the agenda to the M+C organization's representatives (and to CMS's representative, if he or she is in attendance). _____ _____

   d. Hold an exit conference with the M+C organization's representatives. _____ _____

   e. Summarize the results of the exit conference in a memo. Include the names of the attendees. _____ _____

7. Complete quality control documents:

   a. Disclosure checklist. _____ _____

   b. Reporting checklist. _____ _____

   c. Other checklists as appropriate. _____ _____

8. Summarize the completion of the examination in a memorandum. _____ _____

9. Issue an agree/disagree letter, using the model provided by CMS, to the M+C organization containing the list of findings. Include this letter as an attachment to the report. _____ _____

10. Prepare a table of contents that describes the contents of each work paper binder. Include a copy in each binder. _____ _____

11. Arrange for the review of the work papers by the engagement manager, etc. _____ _____

12. Arrange for the review of the work papers by the quality control manager, etc. (Professional Standards Review.) _____ _____

UNIFORM EXAMINATION PROGRAM FOR
ADJUSTED COMMUNITY RATE SUBMISSIONS

PLAN NAME: _____
M+C ORGANIZATION NUMBER: _____
CONTRACT YEAR: _____

13. Make work papers and other audit documentation readily available to CMS for review. Work papers should be maintained for at least 6 years. The work papers should only be submitted to CMS upon request. _____ _____

This page was left blank intentionally.

EXHIBIT A

Excerpt of 42 CFR 422.502(d), (e), and (f)

(d) Maintenance of records. The M+C organization agrees to maintain for 6 year books, records, documents, and other evidence of accounting procedures and practices that—

(1) Are sufficient to the following:
- (i) Accommodate periodic auditing of the financial records (including data related to Medicare utilization, costs, and computation of the ACR) of M+C organization.
- (ii) Enable CMS to inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed under the contract, and the facilities of the organization.
- (iii) Enable CMS to audit and inspect any books and records of the M+C organization that pertain to the ability of the organization to bear the risk of potential financial losses, or to services performed or determinations of amounts payable under the contract.
- (iv) Properly reflect all direct and indirect costs claimed to have been incurred and used in the preparation of the ACR proposal.
- (v) Establish component rate of the ACR for determining additional and supplementary benefits.
- (vi) Determine the rates utilized in setting premiums for State insurance agency purposes and for other government and private purchaser; and

(2) Include at least records of the following:
- (i) Ownership and operation of the M+C organization's financial, medical, and other record keeping systems.
- (ii) Financial statements for the current contract period and six prior periods.
- (iii) Federal income tax or information returns for the current period and six prior periods.
- (iv) Asset acquisition, lease, sale, or other action.
- (v) Agreements, contracts, and subcontracts.
- (vi) Franchise, marketing, and management agreements.
- (vii) Schedules of charges for the M+C organization's fee-for-service patients.
- (viii) Matters pertaining to costs of operations.
- (ix) Amounts of income received by source and payment.
- (x) Cash flow statements.
- (xi) Any financial report filed with other Federal programs or State authorities.

(e) Access to facilities and records. The M+C organization agrees to the following:

(1) HHS, the Comptroller General, or their designee may evaluate, through inspection or other means—

(i) The quality, appropriateness, and timeliness of services furnished to Medicare enrollees under the contract;
(ii) The facilities of M+C organization; and
(iii) The enrollment and disenrollment records for the current contract period and six prior periods.

(2) HHS, the Comptroller General, or their designees may audit, evaluate, or inspect any books, contracts, medical records, patient care documentation, and other records of the M+C organization, related entity, contractor, subcontractor, or its transferees that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce the contract.

(3) The M+C organization agrees to make available, for the purposes specified in paragraph (d) of this section, its premises, physical facilities and equipment, records relating to its Medicare enrollees, and any additional relevant information that CMS may require.

(4) HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through 6 years from the final date of the contract period or completion of audit whichever is later unless—
(i) CMS determines there is a special need to retain a particular record or group of records for a long period and notices the M+C organization at least 30 days before the normal disposition date;
(ii) There has been a termination, dispute, or fraud or similar fault by the M+C organization, in which
(iii) Case the retention may be extended to 6 years from the date of any resulting final resolution of termination, dispute, or fraud or similar fault; or CMS determines that there is a reasonable possibility of fraud, in which case it may inspect, evaluate, and audit the M+C organization at any time.

(f) Disclosure of information. The M+C organization agrees to submit—

(1) To CMS, certified financial information that must include the following:
(i) Such information as CMS may require demonstrating that the organization has a fiscally sound operation.
(ii) Such information as CMS may require pertaining to the disclosure of ownership and control of the M+C organization.

(2) To CMS, all information that is necessary for CMS to administer and evaluate the program and to simultaneously establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. This information includes, but is not limited to:
(i) The benefits covered under an M+C plan;
(ii) The M+C monthly basic beneficiary premium and M+C monthly supplemental beneficiary premium, if any, for the plan or in the case of an MSA plan, the M+C monthly MSA premium.

(iii) The service area and continuation area, if any, of each plan and the enrollment capacity of each plan;

(iv) Plan quality and performance indicators for the benefits under the plan including—

(A) Disenrollment rate for Medicare enrollees electing to receive benefits through the plan for the previous 2 years;

(B) Information on Medicare enrollee satisfaction;

(C) Information on health outcomes;

(D) The recent record regarding compliance of the plan with requirements of this part, as determined by CMS; and

(E) Other information determined by CMS to be necessary to assist beneficiaries in making informed choice among M+C plans and traditional Medicare;

(v) Information about beneficiary appeals and their disposition;

(vi) Information regarding all formal action reviews, findings, or other similar actions by States, other regulatory bodies, or any other certifying or accrediting organization;

(vii) For M+C organization offering an MSA plan, information specified by CMS for CMS's use in preparing its report to the Congress on the MSA demonstration, including data specified by CMS in the area of selection, use of preventive care, and access to services.

(viii) To CMS, any other information deemed necessary by CMS for the administration or evaluation of the Medicare program.

To its enrollees all informational requirements under Section 422.64 and, upon an enrollee's request, the financial disclosure information required under Section 422.516.